Financial Redetermination Form

North Dakota Department of Human Services
SFN 1226 (05-2005)

Client Name:	Client ID:	Case Manager:
Client Address:		

City:	State:	Zip Code:	Home Telephone Number:

RESPONSIBLE PARTY INFORMATION

Last Name:	First Name:		Middle Initial:
Relation to Client:	**Gender:**	**Occupation:**	**Social Security Number:**
Employer:		**Work Telephone Number**:	
Responsible Party Mailing Address:			
City:	**State:**	**Zip Code:**	**Home Telephone Number:**

The Income and Expense section must be completed to be eligible for sliding fee scale:

Is the client a recipient of Medical Assistance (Medicaid)?

☐ **Yes – The client does NOT need to provide proof of income,** since income was provided to county.

☐ **No – Attach income verification documents to this form -** The primary method of income verification is a copy of your most recent pay stubs. Other acceptable documents include benefit notices and bank statements for SSI, SSDI, Interest Income, VA Benefits, etc. If you are self-employed, a seasonal worker, or your income is from a combination of salaries and other income, provide a copy of your most recent income tax form.

- **HOW TO DEFINE FAMILY MEMBERS:**
  - A family is defined as one or more adults and children, if any, related by blood or law, and residing in the same household. Children who are adults (all persons 18 years of age and older) are not considered the responsibility of their parents, even if living in the same household.
- **HOW TO FIGURE FAMILY INCOME:**
  - You must report income from head of household and their spouse.
- **HOW TO FIGURE MEDICAL DEDUCTIONS:**
  - A medical deduction is allowable for any medical insurance paid by the individual and for regular monthly payments on medical bills. The amount deducted must be itemized.

Family Income Information		**Family Expense Information:**	
Number in Family:		**Child Support Payments** (for children not claimed as dependents):	$
Temporary Assistance:	$	**Medical Deductions (Itemize Please):**	$
Gross Wages & Salary:	$		$
Alimony or Child Support: (When counting children as dependents)	$		$
Veterans Benefits:	$		$
SSI/SSDI: (Including dependent children)	$		$
Other Income (Describe Type + Amount):	$	**Child Care Expenses** (incurred because of employment):	$
	$	**Alimony Paid:**	$
	$	**Nursing Home Expense:**	$
TOTAL INCOME:	$	**TOTAL EXPENSE:**	

OVER

Insurance Information and/or Medical Assistance (Medicaid) Information

We need a copy of your insurance card, if not previously provided. If you don't have a card, contact your insurance carrier. Failure to provide us with insurance company information will result in FULL FEE for services.

Primary Insurance:	Secondary Insurance:	Tertiary Insurance:
Insurance:	Insurance:	Insurance:
Effective Date of Policy:	Effective Date of Policy:	Effective Date of Policy:
Policy #:	Policy #:	Policy #:
Client's Relation to Policyholder: Child ☐ Other ☐ Self ☐ Spouse ☐	Client's Relation to Policyholder: Child ☐ Other ☐ Self ☐ Spouse ☐	Client's Relation to Policyholder: Child ☐ Other ☐ Self ☐ Spouse ☐
Policy Holder's full name:	Policy Holder's full name:	Policy Holder's full name:
Policy Holder's Address:	Policy Holder's Address:	Policy Holder's Address:
Policy Holder's City, State, Zip:	Policy Holder's City, State, Zip:	Policy Holder's City, State, Zip:
Policy Holder's Phone Number:	Policy Holder's Phone Number:	Policy Holder's Phone Number:
Policy Holder's Employer:	Policy Holder's Employer:	Policy Holder's Employer:
Policy Holder's Work Phone Number:	Policy Holder's Work Phone Number:	Policy Holder's Work Phone Number:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Gender: Female ☐ Male ☐	Policy Holder's Gender: Female ☐ Male ☐	Policy Holder's Gender: Female ☐ Male ☐
Group Number (if applicable):	Group Number (if applicable):	Group Number (if applicable):
Plan Number (if applicable):	Plan Number (if applicable):	Plan Number (if applicable):

Federal Regulations state the following must be billed to you at full fee. We cannot apply the sliding fee scale to: Medicare deductible or copay, or Medical Assistance (Medicaid) Recipient Liability.

Privacy Statement: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

I certify that the information provided is true to the best of my knowledge. I authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services for the purpose of verifying income. **I understand that if any information necessary to verify my income is not provided, the Human Service Center will charge me the FULL FEE for any service provided.** This authorization will remain valid until I no longer receive services from the Human Service Center or until I revoke it in writing. A copy of this authorization is as valid as the original.

Signature of Responsible Party or Legal Representative:	**Date:**

Office Use:	Income Verified?	Sliding Fee Discount:	HSC Staff initials:	Date Entered: